

June 13, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: File code CMS-1607-P

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) acute and long-term care hospitals proposed rule, published in the *Federal Register* on May 15, 2014. The proposed rule addresses the hospital inpatient prospective payment system for acute care hospitals and the long-term care hospital prospective payment system. In view of their competing demands and limited resources, we especially appreciate your staff's efforts to improve hospital payment systems.

In this letter we comment on seven issues in the FY2015 proposed rule.

- **Quality metrics:** We support CMS's proposals in the hospital quality reporting and value-based purchasing programs to decrease the number of process measures and increase the number of outcome measures, but have concerns about proposed condition-specific efficiency/cost measures.
- **Uncompensated care:** We see two problems with the proposal for distributing uncompensated care dollars. First, using each hospital's number of Medicaid days and Medicare SSI (supplemental security income) inpatient days as a proxy for their uncompensated care costs will result in misallocating uncompensated care dollars. Data from worksheet S-10 in hospitals' annual Medicare cost reports provides a better estimate

of uncompensated care costs. Second, the proposal to distribute the uncompensated care payments as a per-discharge add-on payment is problematic because the per-discharge add-on varies widely from hospital to hospital. The variability of the add-on distorts the MS-DRG pricing system and creates problematic incentives for ACOs and MA plans. It would be better to adjust all DSH hospitals' payments in a county by an equal amount per discharge to account for the county-wide average level of uncompensated care. Any underpayments or overpayments to an individual hospital could be corrected at year-end settlement (as is already necessary under the current system). This change coupled with using the worksheet S-10 data would improve the allocation of uncompensated care payments and avoid the distortions in MS-DRG prices caused by the method suggested in the proposed rule for FY2015.

- **Readmissions:** The readmissions policy is having the desired effect of inducing hospitals to make greater efforts to coordinate care and reduce readmissions. However, there is an urgent need to improve the methods used to compute readmission rates and set readmission targets. This year's proposal adds two new conditions to the readmission measure; the inordinate impact of excess readmissions for one of those conditions highlights the importance of changing these aspects of the readmission policy as soon as possible.
- **Short stays and the 2-Midnight policy:** The Commission shares CMS' concerns about the three issues that CMS said motivated the 2-Midnight policy — growth in observation cases, the financial implications for beneficiaries' out-of-pocket costs and potential for beneficiary confusion, and ambiguity in Medicare's inpatient admission criteria. However, the 2-Midnight policy may not address these issues as effectively as possible. We have several additional concerns with the current framework: the 2-Midnight threshold, transparency for beneficiaries, administrative burden on hospitals, and inequity in payment between similar cases treated as short inpatient stays versus outpatient observation stays. In our upcoming work cycle, the Commission intends to explore alternative short-stay policies that might better address these concerns.

- **Wage index:** MedPAC has recommended changing the law governing the wage index system. We proposed replacing the current wage index system and all of its exceptions with a new wage index system described in our June 2007 report to Congress.
- **Charge master transparency:** Hospitals are essential participants in the effort to develop a culture of price transparency. We are concerned that the proposed guidelines for implementing hospital charge transparency under the Patient Protection and Affordable Care Act may offer hospitals the opportunity to avoid making their charge-master prices readily available to the public. We suggest that CMS revise the proposed transparency guidelines to require that hospitals post their charges on the internet rather than be allowed to only make public “their policies for allowing the public to view a list of those charges in response to an inquiry.”
- **Medicare Advantage encounter data:** We support the proposal to release Medicare Advantage plans’ encounter data. This could lead to a better understanding of MA plans and may stimulate ideas for how both the FFS and MA payment systems could improve.
- **LTCH payments in 2016:** Beginning in fiscal year 2016, Medicare will pay differently for some cases in long-term care hospitals (LTCHs). Under the Pathway for SGR Reform Act of 2013, Medicare will pay “site-neutral” rates, based on what Medicare pays for similar cases in acute care hospitals, unless the LTCH case had an immediately preceding acute care hospital stay that (a) included at least three days in an intensive care unit or (b) the case has an LTCH principal diagnosis indicating the receipt of prolonged mechanical ventilation. In this letter, we have provided feedback to inform setting 2016 payment rates and modifying the LTCH sort-stay outlier rule.

Hospital quality reporting and value-based purchasing programs

In general, we support CMS's proposal to decrease the number of process measures and increase the number of outcome measures, but have concerns about proposed condition-specific efficiency/cost measures.

CMS proposes to decrease the total number of measures required for the Inpatient Quality Reporting (IQR) program from 57 in FY 2014 to 46 in FY 2015. The proposed changes would:

- Delete 15 clinical process measures that require hospitals to extract and report data from patient medical records,
- Add two outcome measures that would use Medicare claims data to calculate rates of readmission and mortality within 30 days following coronary artery bypass graft (CABG) surgery, and
- Add two new "efficiency" measures that would be based on a hospital's risk-standardized costs for 30-day episodes of care related to treatment for pneumonia and heart failure.

CMS proposes similar changes to the measure set used for the Hospital Value-Based Purchasing (VBP) program in FY 2017, deleting six process measures that rely on data extracted from medical charts and adding two patient safety measures of rates of healthcare-associated infections. CMS also asks for comments on the desirability of adding six condition-specific episode-based cost measures to the VBP program in the future.

The Commission has urged for several years that Medicare's quality measurement system should move away from the use of clinical process measures and toward the use of outcome measures, and therefore we appreciate and strongly support CMS's proposals to reduce the number of process measures that use medical chart-abstracted data. We also support adding to the IQR program the claims-based measures of 30-day mortality and readmission rates following CABG surgery.

However, we are concerned about the two measures of 30-day episode costs for pneumonia and heart failure proposed for the IQR, and about the six condition-specific cost measures CMS discusses as potential future additions to the VBP program. We previously supported adding the Medicare Spending per Beneficiary (MSPB) measure to the IQR and VBP programs, because we agree that hospital performance should be evaluated both on the quality of care and the cost of care. However, the proposed condition-specific cost measures would have smaller numbers of hospital-specific observations than the current all-condition measure which pools information from all inpatient conditions. Splitting the pool of information on costs into condition-specific measures would result in more random variation without providing clear additional information about the average costliness of the hospitals' care. To ensure reliability, we believe it is important that the cost measures used should be as broadly based as possible. Therefore we do not support the use of the proposed condition-specific cost measures in the IQR or VBP programs.

Uncompensated care payments

CMS proposes to distribute uncompensated care dollars using the number of Medicaid days and Medicare SSI days as a proxy for hospitals' uncompensated care costs, as the agency did for FY2014. CMS argues that data on uncompensated care costs collected on Worksheet S-10 in hospitals' annual Medicare cost reports is not yet reliable enough to use to distribute uncompensated care payments. The commission believes, however, that the proposed methodology will result in misallocating uncompensated care dollars. While the data from Worksheet S-10 is not perfect, this form is designed to collect uncompensated care data and in our view would provide a better estimate of uncompensated care costs. We also believe that the proposal to distribute the uncompensated care payments as a per-discharge add-on payment is problematic because the per-discharge add-on varies widely from hospital to hospital. The variability of the add-on payments distorts the MS-DRG prices and creates problematic incentives for ACOs and MA plans. It would be better to have a common add-on payment for all DSH hospitals in a county. Any underpayments or overpayments to an individual hospital could be

corrected at year-end settlement or on an interim basis during the year (as is already necessary under the current system).

Estimating the amount of uncompensated care

Historically Medicare has paid higher inpatient payment rates to hospitals with a high share of low-income patients, as measured by the disproportionate patient percentage (DPP). The DPP is computed as the sum of two fractions: the “Medicare SSI fraction” and the “Medicaid fraction.” The “Medicare SSI fraction” is the hospital’s share of Medicare patients that are low-income; it is computed as the share of Medicare inpatient days attributable to patients entitled to Supplemental Security Income (SSI). The Medicaid fraction is the hospital’s share of total inpatient days attributable to Medicaid patients. The net effect of the policy is to pay higher inpatient rates for low-income Medicare patients and indirectly subsidize Medicaid patients with Medicare inpatient dollars.

The original justification for Medicare DSH payments was that poor Medicare patients were thought to be more expensive in ways that were not accounted for by the original DRG system. By 2011, both the Commission and other researchers concluded that, at most, 25 percent of the DSH payments were empirically justified by the higher costs at hospitals treating low-income *Medicare* patients.¹ Therefore, hospitals that served high shares of Medicaid patients were given higher payments than justified by the costs of their Medicare patients.

Some have argued that DSH payments should remain to assist hospitals that serve poor patients with their higher *non-Medicare* uncompensated care burdens. However, in 2007 the Commission found that the DPP was a poor predictor of uncompensated care costs.² In other words, the DSH

¹ Nguyen, N. X., and S. H. Sheingold. 2011. Indirect medical education and disproportionate share adjustments to Medicare inpatient payment rates. *Medicare & Medicaid Research Review* 1, no. 4: E1-E19.
Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC

² Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC

formula failed to direct significantly higher payments to hospitals with high amounts of non-Medicare uncompensated care costs.

In 2010, Congress enacted several changes in the DSH payment policy in the Patient Protection and Affordable Care Act (PPACA). The overall size of the pool of dollars available for DSH and uncompensated care payments is determined using the same DPP method that was previously used to determine the DSH pool. The key changes taking place beginning in fiscal year 2014 is that the pool of dollars for DSH payments and uncompensated care payments is allocated into the following categories:

- CMS pays 25 percent of the pool based on the **DSH** formula.
- The remaining 75 percent of the pool is divided into two parts.
 - One part is used to create a pool of dollars to pay for **uncompensated care** at hospitals. The size of the pool depends on the change in the number of uninsured individuals in the country. The distribution of the residual pool depends on each hospital's share of uncompensated care.
 - As the number of uninsured individuals falls, the Medicare funds allocated to helping hospitals pay for uncompensated care will decrease. The remainder of the funds not allocated to uncompensated care will be allocated to **trust-fund savings**. For every 1 percent decline in the rate of uninsurance, the share of the DSH pool allocated to uncompensated care payments will decline by 1 percentage point and the share allocated to trust fund savings will increase by 1 percentage point.
- In 2015, we expect the total pool of dollars distributed as either DSH or uncompensated care payments will decline slightly from FY2014 due to the declining share of the nation's population that is uninsured. The effect of declining national rates of uninsurance on the share of the pool dedicated to uncompensated care will be partially offset by the effect of expanded Medicaid rolls on the size of the pool available for DSH and uncompensated care payments.

The net result of these changes in DSH and uncompensated care payment policy is to:

- Bring DSH payments down toward an empirically justified level (25 percent of the past level).
- Shift Medicare from implicitly subsidizing Medicaid to explicitly subsidizing uncompensated care. This is a major change in the use of trust fund dollars.
- Lower the amount of Medicare dollars spent on uncompensated care as rates of uninsurance decline.

CMS has been given the challenging task of implementing this law. We agree with several steps CMS is taking, but have reservations about the continued use of Medicaid and SSI days as a proxy for a hospital's uncompensated care costs. The proposed rule states that "data on utilization for insured low-income patients can be a reasonable proxy for the treatment costs of uninsured patients." In contrast with this assumption, our 2007 analysis of data from the GAO and data from the American Hospital Association (AHA) suggests that Medicaid days and low-income Medicare days are not a good proxy for uncompensated care costs.³ Given our prior findings that the Medicaid and SSI shares were poor predictors of uncompensated care costs, it is clear that there is a need to transition to new measures.

Worksheet S-10 in the Medicare cost report provides an alternative measure of uncompensated care burdens that could begin to replace the reliance on Medicaid and SSI shares. Charity care for the uninsured is reported on the form S-10 (line 23 column 1) and would be a reasonable proxy for the costs of treating the uninsured. The law explicitly gives the Secretary the authority to use data that is the best proxy for the "costs of subsection (d) hospitals treating the uninsured." Line 23 Column 1 would fit this aspect of the law.

Some have raised concerns about whether the quality of the data reported on Worksheet S-10 is adequate for use in distributing uncompensated care payments. We have examined the data and agree it may not be perfect for all hospitals; however, it is much better than using Medicaid and

³ Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

SSI days. To the extent that CMS believes some uncompensated care cost values are unusually high or low, it could instruct the MACs to work with the hospitals to consistently file their cost reports and re-file Worksheet S-10 if need be. The data on Worksheet S-10 will improve over time as it is used in making payments and is already better than using Medicaid and SSI days as a proxy for uncompensated care costs. It is also important to note that the S-10 data currently available would only establish an interim allocation of uncompensated care payments; the final allocation of payments to each hospital is determined based on the S-10 data available at year-end settlement. To prevent financial shocks to hospitals, CMS could transition to use of the S-10 data over three years.

Distributing the uncompensated care payments

The proposed rule for FY 2014 had originally proposed making the uncompensated care payments directly to hospitals without tying the payments to the DRG pricing system. However, many hospitals representatives told us that their contracts with managed care companies are based on the price computed by the Medicare FFS “pricer.” Thus, hospitals were concerned that if the uncompensated care payments were not in the “pricer” program CMS uses to compute the price for each FFS discharge, managed care companies would not make any payments for their share of uncompensated care costs. Because the uncompensated care payments are included in the Medicare Advantage (MA) plans’ benchmarks, the MA plans should be expected to pay those amounts to hospitals. The FY2014 final rule addressed this concern (of MA prices being based on the FFS pricer) by making each hospital’s uncompensated care payments an add-on in the pricer. CMS then reconciles any overpayments or underpayments to a hospital through the annual year-end settlement.

The problem with this method is that the add-on payment varies widely among hospitals and is large for hospitals with many Medicaid days and few Medicare days. The add-on payment is less than \$100 per discharge for some DSH hospitals, but is over \$1,000 for 768 hospitals and over \$10,000 per discharge for 24 hospitals. This hospital-specific add-on can be much larger than the add-on payment under the old DSH system and distorts incentives for ACOs and MA plans. For

example, ACOs or MA plans could direct patients away from hospitals serving the uninsured and toward hospitals without the uncompensated care payment. This could result in thousands of dollars (per discharge shifted) of additional profit for MA plans or potential for gain sharing for ACOs without any real change in service use or savings for the Medicare program. The regulatory solution for this distortion in pricing is to make the add-on equal across DSH hospitals and correct for any under- or over-payments through direct interim payments and the year-end settlement process.

The first step toward equalizing the add-on payment would be to divide all uncompensated care dollars due to hospitals in each county by all Medicare discharges in the county at hospitals that receive DSH dollars. This would generate a county-level per discharge amount for every DSH hospital in a given county. This add-on would also be in the pricer for all DSH hospitals. Therefore, this per discharge amount would apply to contracts between MA plans and hospitals that are based on the FFS pricer.⁴ This would fix the distortion in the pricing system caused by uncompensated care payments and greatly reduce the incentive to shift Medicare MA and ACO patients away from hospitals serving the uninsured.

Using a fixed payment per discharge for all hospitals in a county would result in CMS initially overpaying uncompensated care dollars to some hospitals with low uncompensated care levels and initially underpaying hospitals with high uncompensated care burdens. CMS would correct these over or under payments through reconciliation at the end of each quarter by making interim payments to hospitals. This should be a minimal extra administrative burden given that CMS already does a year-end reconciliation to the current system to correct for any differences between the uncompensated care payments paid to a hospital through the per-discharge add-on and the actual level of uncompensated care payments due to the hospital.

⁴ This would also be the price MA plans pay hospitals for out-of-network services. The law mandates that MA plans pay hospitals the FFS price determined by the pricer when the MA plan is responsible for the cost of care and there is no contractually negotiated price between the MA plan and the hospital.

The hospital readmissions reduction program needs statutory changes

CMS' proposed implementation of the current law governing the Medicare readmission policy is reasonable; however, the Commission has identified urgently needed changes in the law.

The program is designed to reduce payments to hospitals that have excess readmissions and encourage them to reduce their readmission rates. Doing so requires a measure of readmissions, a method for determining excess readmissions, and a formula for computing penalties for hospitals with excess readmissions. Current law is highly prescriptive in how the readmission policy is implemented. We concur that the implementation proposed is aligned with current law.

However, as we explain in our June 2013 report to Congress, we have serious concerns with the law governing readmissions. Specifically, the law must be refined to address four issues with the current policy:

- The readmission penalty formula is flawed. Aggregate penalties would remain constant even if national readmission rates decline. More importantly, the condition-specific penalty per excess readmission is higher for conditions with low readmission rates. This issue becomes more important in 2015 when elective total hip and total knee arthroplasty (low readmission rate conditions) are added to the readmission policy. To avoid large penalties for small numbers of excess readmissions and to retain incentives for hospitals to provide these services, the basic penalty formula needs to be changed now.
- Single-condition readmission rates face significant random variation due to small numbers of observations.
- Heart failure readmission rates are inversely related to heart failure mortality rates.
- Hospitals' readmission rates and penalties are positively correlated with their low-income patient share. This puts hospitals that treat a large share of low income patients at a financial disadvantage under the current program.

To address these concerns we discussed using an all-condition readmission measure with a fixed target in our June 2013 report. The readmission “multiplier” would be removed from the formula and replaced with a penalty that roughly equals the cost of excess readmissions over a fixed target level of readmissions. Given a fixed target, penalties would decline if hospitals’ collective performance improves. In addition, to address the issue of readmission rates and penalties being correlated with patient income, we discuss evaluating hospital readmission rates against a group of peer hospitals with a similar share of low-income Medicare beneficiaries as a way to adjust readmission penalties for socioeconomic status. These actions require immediate legislative changes because the current formula used to compute the readmission penalty is set in law.

Short inpatient hospital stays and CMS’s 2-Midnight Policy

For several years the Commission has tracked the growth of observation cases and the shift of short-stay cases from the inpatient setting to the outpatient setting. We believe these trends reflect at least in part hospitals’ responses to the ambiguity of Medicare requirements for inpatient admission, coupled with underlying payment inequities between clinically similar inpatient and outpatient cases. These factors influenced Medicare’s Recovery Audit Contractors (RAC) and Medicare Administrative Contractors (MAC) to focus on the appropriateness of short inpatient stays. Their scrutiny led hospitals in turn to increase their use of observation status. To date, the Commission has not made recommendations to CMS or the Congress concerning short inpatient stays, but has expressed concern that the growth in observation cases may adversely affect beneficiaries’ out-of-pocket costs. Based on this and other concerns, the Commission is currently assessing policy alternatives to address the complexities of the short inpatient stay issue and CMS’s 2-Midnight policy.

The Commission has a broad range of concerns related to short inpatient stays and the 2-Midnight policy which we encourage CMS to consider as it re-examines policy in this area. The Commission shares CMS’ concerns about the three issues that motivated the 2-Midnight policy -- rapid growth in observation cases, the financial implications on beneficiaries’ out-of-pocket costs

and potential for beneficiary confusion, and ambiguity in Medicare's inpatient admissions criteria. While we agree that these issues are important, we are not convinced that the 2-Midnight policy addresses them as effectively as possible. In addition, we have other policy concerns that are either generated by the 2-Midnight policy or remain untouched by the 2-Midnight policy. Specifically, we are concerned about inequities in payment under the 2-Midnight policy, the potential for confusion for beneficiaries, and the administrative burden on providers.

- Defining inpatient cases as those which are present in the hospital for two consecutive midnights may not sufficiently resolve the ambiguity of the Medicare admission criteria. The 2-Midnight policy creates a timing inequity whereby cases are paid differently depending upon whether they were admitted just before or just after midnight, assuming both cases remained in the hospital past the next midnight. While just a few minutes may separate these admissions, the first is presumed to be an inpatient admission and the second is presumed to be an outpatient observation stay. One possible resolution of this inequity might be for CMS to establish a threshold for inpatient admission based on the number of hours a patient is treated in the hospital. This would require CMS to incorporate a new variable on hospital claims which identifies either the number of hours the beneficiary received care in the hospital, or the exact time that the hospital began providing care. The former currently exists for observation cases but not for inpatient or non-observation outpatient claims.
- We are also concerned about the underlying payment inequity between clinically equivalent inpatient and outpatient short-stay cases. Currently, clinically equivalent short-stay inpatient and outpatient cases are paid at different rates. Higher rates for inpatient cases provide hospitals with the financial incentive to admit beneficiaries when possible. Any alternative policy that deals with short inpatient stays may need to reduce or eliminate the differences in payment between short inpatient stays and outpatient stays of the same length in order to reduce the financial incentive to admit beneficiaries who could be treated effectively in an outpatient setting.
- Any new policy related to admission criteria also should be transparent for beneficiaries. Clear program rules that allow beneficiaries to know their inpatient/outpatient status at all

times are needed to enable beneficiaries to make rational and efficient decisions about their care.

- Finally, with respect to the inpatient admission order and certification requirements we are concerned that the 2-Midnight policy may increase administrative burden without yielding significant benefit to the program, beneficiaries, or providers. Under the 2-Midnight policy, a physician must formally order in the medical record that the patient be admitted to inpatient services and certify that the beneficiary is expected to stay at least two midnights in the hospital. Despite these administrative requirements, inpatient cases may still be subject to the RAC audit process. For example, if a case has been certified by a physician as being expected to last at least two midnights, but due to clinical circumstances the patient leaves the hospital prior to the second midnight, a RAC may initiate an audit up to 3 years later.

The Commission intends to explore alternative short inpatient stay policies that might better address the various concerns about short inpatient stays and the 2-Midnight policy. In the FY 2015 IPPS Proposed Rule, CMS posed two primary questions with regard to a short stay policy: (1) how to define a short inpatient stay and (2) how to determine appropriate payment once a short stay is identified.

With respect to the first question, CMS points out that there are at least two kinds of short inpatient stays: short stays in diagnosis related groups (DRG) where the average length of stay (ALOS) is relatively short (e.g., chest pain) and short stays in DRGs where the ALOS is relatively long (e.g., septicemia). We intend to consider both types of short inpatient stays in our work. The short-ALOS-DRGs account for a substantial share of 1-day stays and are associated with conditions that account for a substantial portion of outpatient observation stays. Thus, it would be important that any new alternative short stay policy address the short-ALOS-DRGs. There may also be value in considering a short stay policy for the long-ALOS-DRGs. While the idea of a flat DRG payment is to promote efficiency, it is questionable whether the provision of a full DRG payment to a 1-day stay in a long-ALOS-DRG serves that purpose.

With respect to the second question -- how a short stay payment adjustment might be structured -- we intend to explore a number of approaches. It is possible that a new short-stay policy might differ depending on the type of DRG. For example, as CMS notes, a policy that builds off of the existing post-acute care transfer policy might be a starting point for long-ALOS-DRGs, but would not be effective for short-ALOS-DRGs. For short-ALOS-DRGs, we intend to explore a variety of different approaches to reducing or eliminating the difference in payments between short inpatient stays and outpatient stays. As we explore the potential for an alternative short stay policy, we intend to assess the implications of various approaches for Medicare program spending, beneficiary liability, hospital profitability, other IPPS DRG payment rates, and other related policies (e.g., SNF 3-day rule, hospital readmissions policy, hospital transfer policy, hospital rebilling policy).

In addition, as we noted above, scrutiny of short inpatient stays by the RACs contributed to the increase in observation stays and the establishment of the 2-Midnight policy. Program oversight is, of course, essential as a safeguard for the Medicare program, beneficiaries, and taxpayers. However, it is also important to strike a balance between the need for oversight and administrative burden. Because any alternative short inpatient stay policy would ultimately interact with the RAC program, we will continue to develop policy strategies that might achieve that balance.

Proposed changes to the hospital wage index for acute-care hospitals

The proposed rule requests comments on a variety of detailed hospital wage index issues. In general, phasing in the changes stemming from the new decennial census is appropriate. However, we wish to reiterate our recommendations on wage index reform, included in the Commission's 2007 Report to Congress, which were to repeal the existing hospital wage index statute and to replace it with a new wage index system described below. The repeal of the current system would include removing reclassifications stipulated in law and adjustments implemented through regulation (e.g., the imputed rural floor in FY 2015), and give the Secretary the authority to

establish a new wage index system. Our 2007 recommendations stated that the law should be changed to establish a new hospital compensation index so that it:

- Uses compensation data from all employers together with hospital industry-specific occupational weights;
- Is adjusted for geographic differences in the ratio of benefits to wages;
- Is adjusted at the county level to smooth large differences between counties; and
- Is implemented so that large changes in wage index values are phased in over a transition period.

The system we proposed is similar to a recommendation by the Institute of Medicine and was intended to replace the system of geographic reclassification and exceptions that is currently in place.⁵

Hospital standard charge transparency

Section 2718(e) of the Public Health Service Act, a sub-section of PPACA, mandates that each hospital operating within the United States shall make public a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act. This section also mandates that these data are made public in accordance with guidelines developed by the Secretary of HHS. In the FY 2015 IPPS Proposed Rule CMS reminds providers of the requirement "that hospitals either make public a list of their standard charges (whether that be the chargemaster itself or in another form of their choice), or their policies for allowing the public to view a list of those charges in response to an inquiry." We are concerned that the second half of these guidelines may create an opportunity for hospitals to avoid making their standard charges readily available to the public.

⁵ Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare*. Washington, DC: MedPAC. Institute of Medicine. 2011. *Geographic adjustment in Medicare payment, Phase I: Improving accuracy. Second edition*. Washington, DC: The National Academies Press.

CMS's recent efforts at releasing Medicare providers' (hospitals and physicians) utilization and payment data are a positive step toward making the health care marketplace more affordable and providers more accountable. However, hospitals are essential to the development of a culture of price transparency in our health care system. We suggest that CMS require hospitals to publicly post their charges on the internet rather than allow hospitals to only post "their policies for allowing the public to view a list of those charges in response to an inquiry."

Medicare Advantage encounter data

Medicare Advantage organizations are required to submit risk adjustment data to CMS, including "encounter data" that is roughly equivalent to Medicare fee-for-service claims data. Encounter data contains the context and purposes of items and services provided to plan enrollees by a provider, supplier, physician, or other practitioner. In this rule, CMS lays out a proposal to expand the allowed uses for Medicare Advantage encounter data, and expands the entities to which CMS could release encounter data for such purposes. We support CMS' proposal for expanding the use and distribution of Medicare Advantage encounter data.

Implementing changes to the long-term care hospital (LTCH) prospective payment system (PPS)

The Pathway for SGR Reform Act of 2013 establishes "site-neutral" payments for specified cases in LTCHs, beginning in fiscal year 2016. Under the law, LTCH payment rates will be allowed only for LTCH discharges that had an immediately preceding acute care hospital stay (ACH) and:

- the ACH stay included at least three days in an intensive care unit, or
- the discharge receives an LTCH principal diagnosis indicating the receipt of mechanical ventilation services for at least 96 hours.

All other LTCH discharges—including any discharges assigned to psychiatric or rehabilitation Medicare severity long-term care diagnosis related groups (MS-LTC-DRGs), regardless of

intensive care unit use—will be paid an amount based on Medicare’s ACH payment rates under the IPPS or 100 percent of the costs of the case, whichever is lower. These site-neutral payments will be phased in, with payments in fiscal years 2016 and 2017 a blend of one-half the standard LTCH payment rate and one-half the site-neutral rate.

In the May 15, 2014 proposed rule, CMS states its intention to propose during the FY 2016 rule-making cycle the specific policy and payment changes that will be necessary to implement the new law. The agency requests public feedback to inform this upcoming proposal.

Setting base payment rates for LTCH services

The Pathway for SGR Reform Act establishes two distinct payment groups for LTCH discharges under a revised payment system. Discharges meeting specified patient-level criteria will be paid under the “standard LTCH PPS payment amount.” All other discharges will be paid under a “site neutral” payment rate based on Medicare’s payment for similar cases under the IPPS. Historically, CMS has based its LTCH payment rates and relative weights for each MS-LTC-DRG on data for *all* LTCH cases. The Commission believes, however, that under the new law, CMS should calculate a new LTCH base payment rate and new relative weights for each MS-LTC-DRG based solely on the most recent available standardized data associated with discharges meeting the specified patient-level criteria. These discharges are considered under the law to be the most severely ill and therefore to have higher resource costs warranting higher LTCH payments. MedPAC believes that this change in methodology should not increase aggregate payments for the cases that remain in the LTCH payment system—aggregate LTCH payments for these “LTCH appropriate” patients should be held to the same aggregate payments these cases receive currently.

Setting outlier payments for LTCH discharges with extraordinarily high costs

The Commission believes that, under the new law, CMS should continue to make additional payments for all LTCH cases that qualify as high-cost outliers, whether the case is paid the standard LTCH PPS payment amount or the site-neutral amount. Total outlier payments in the LTCH payment system should continue to account for 8 percent of total LTCH payments for all

LTCH cases (combined). The Commission believes that the same uniform national fixed loss amount should be applied both to cases being paid the standard LTCH PPS payment amount and to cases being paid the site-neutral amount.

Adjusting payments for LTCH cases with unusually short stays

In the LTCH payment system, Medicare may adjust payments for cases with short stays. Currently, CMS defines a short-stay outlier (SSO) case as having a length of stay less than or equal to five-sixths of the geometric average length of stay for the case type (MS-LTC-DRG). Payment for most SSO cases is generally considerably lower than the payment for a non-SSO case in the same MS-LTC-DRG. LTCHs therefore have a strong financial incentive to keep patients until their lengths of stay exceed the SSO threshold for the relevant case type. MedPAC analyses of LTCH discharge patterns have shown that LTCHs respond to that incentive. Analyses of lengths of stay by MS-LTC-DRG have consistently shown that the frequency of discharges rises sharply immediately after the SSO threshold. This pattern holds true across MS-LTC-DRGs and for every category of LTCH. The data strongly suggest that LTCHs' discharge decisions are influenced at least as much by this financial incentive as by clinical considerations.

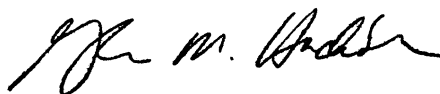
The SSO policy reflects the notion that patients with lengths of stay similar to those in acute care hospitals should be paid at rates comparable with those under the IPPS. Under the Pathway for SGR Reform Act, LTCH cases not meeting the specified patient criteria will be paid site-neutral rates comparable with those under the IPPS. The Commission therefore believes that these cases should be subject to the same short-stay policies that apply in the IPPS.

However, cases that meet the specified patient criteria and that are paid based on the standard LTCH PPS payment amount should continue to be subject to the SSO policy. The Commission believes that the SSO thresholds for each MS-LTC-DRG should be calculated based solely on the most recent available length of stay data associated with discharges meeting the specified patient-level criteria. Cases being paid based on site-neutral rates should be excluded from these calculations. Further, the Commission believes that CMS should reduce the financial incentives for

LTCHs to lengthen stays unnecessarily by lowering the payment penalty for discharging patients before the SSO threshold. For example, short-stay cases could be defined as cases with a covered length of stay that is more than one day shorter than the geometric average length of stay for the MS-LTC-DRG. As with the transfer policy for short-stay cases in the IPPS, payment for the first day of a short-stay LTCH case could be two times the per diem payment rate for the MS-LTC-DRG; payment for each additional day would then be set at the per diem rate, up to the maximum of the full standard per discharge payment (which would be reached one day before the average length of stay for the DRG). This formula would reduce the substantial cliff in payments that exists under current policy and better match incremental payments for short-stay cases to the provider's incremental costs.

If you have questions about any of the issues raised in our comments, please contact Mark Miller, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth".

Glenn M. Hackbarth, J.D.
Chairman